TDMHSAS Use Only: Date Received _____ Date Completed _____ ❑ approved ❑ denied ❑ pending

TENNESSEE DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

Certified Peer Recovery Specialist Renewal Application

Type or write legibly in black or blue ink. Renewal Applications are due fourteen (14) calendar days prior to the recertification deadline. Email the completed Renewal Application and accompanying continuing education certificates to CPRS.TDMHSAS@tn.gov or fax to 615-253-3920.

Name _____ Date _____

Certification Number _____ Certification Date _____

Address _____

City, State, ZIP _____

Phone (with area code) _____

Email (required) _____

Social Security Number _____

Continuing Education

Ten (10) hours of continuing education are required annually to maintain certification and must be earned within the certification period. Refer to Continuing Education Guidelines of the CPRS Handbook (http://www.tn.gov/behavioral-health/topic/certified-peer-recovery-specialist-program). For each training, include a copy of the certificate of attendance or completion. Note: TDMHSAS-approved on-line trainings are limited to five (5) hours out of the 10 hours required, and a minimum of one (1) hour of continuing education per year must be in ethics.

Title of Training _____ Number of Hours_____

Title of Training _____ Number of Hours_____

Title of Training _____ Number of Hours_____

Title of Training _____ Number of Hours_____

Title of Training _____ Number of Hours_____

Title of Training _____ Number of Hours_____

Title of Training _____ Number of Hours_____

Title of Training _____ Number of Hours_____

Title of Training _____ Number of Hours_____

Title of Training _____ Number of Hours_____

My signature below affirms that all of the information contained in this application is true and correct to the best of my knowledge and has been completed by no other person. I understand that knowingly providing false information shall be grounds to deny or revoke my certification.

CPRS signature _____ Date _____

CPRS printed name _____

Employment/Volunteer Service Summary

This section is to be completed by the supervising behavioral health professional. All Certified Peer Recovery Specialists must be under the general supervision of a behavioral health professional in accordance with acceptable guidelines and standards of practice by the State and as defined in the TDMHSAS Licensure rules, Chapter 0940-05-01.

Supervisor _____Credentials _____

Title _____

Agency/Organization _____

Address _____

City, State, ZIP _____

Phone (with area code) _____

Email_____

CPRS's position within the agency_____

CPRS has provided a minimum of 25 hours of peer support services in the past year? ❑ YES ❑ NO

CPRS has received supervision from a behavioral health professional in accordance with the CPRS Handbook? *(see link on previous page)* ❑ YES ❑ NO

My signature below affirms that all of the information contained in this document is true.

Signature of Supervisor _____ Date_____